NOVA SCOTIA

Department of Justice

REFORM OF THE

FATALITY INQUIRIES ACT

DISCUSSION PAPER

February, 2000

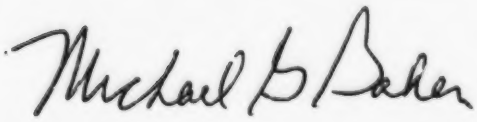
Letter from the Minister

For most of you reading this paper, the fact the *Fatality Inquiries Act* requires some reform will not come as a surprise. There have been concerns raised about this legislation over the past number of years and this Consultation Paper is the first step in a process to reform the death investigation process in Nova Scotia.

This Consultation Paper highlights the major concerns and provides some options for your consideration. You will note in reading the Paper that no recommendations are made. Government has not made determinations on the issues raised in the Paper because we would like to have input from all interested parties prior to reaching conclusions on these issues.

In the first phase of the consultation process we are inviting written submissions from you on some or all of the questions raised in this Paper. Following that, we anticipate having discussions with representatives from various interest groups. Once the consultation process is complete, I will propose legislation having considered all of the presentations that have been received.

The aim of the process is to have legislation that best serves both those who require the services provided by a death investigation system and those who provide the service. Your input is vital to this process and this Government is committed to listening to your concerns.



Michael G. Baker
Minister of Justice

DEDICATION

This paper is based on research completed in February, 1999 by Barbara Patton. Barb died of cancer just as she completed the research paper. It could be said that Barb lost her battle with cancer on February 25, 1999. Well yes, every champion loses a final battle of one sort or another. But Barb fought a new battle with cancer every day. This work is public evidence of the thousand battles she won.

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FOREWORD

This Discussion Paper is a shortened summary version of a detailed research paper prepared by Barbara Patton of the Department of Justice in February, 1999, which examines the *Fatality Inquiries Act* and the need for reform of this legislation. That paper is over 100 pages long and contains extensive footnotes. For the purpose of generating discussion, it was thought that a shortened version would be more manageable. For ease of reading, the footnotes citing the sources of various material used in the summary do not appear in this Discussion Paper. No plagiarism is intended and readers are directed to the main paper for any questions of attribution. Ms. Patton is not responsible for any errors that have occurred in the editing and summarization of her work in this manner. Copies of Ms. Patton's paper are available from the Dept. of Justice and from the Department's website: http://www.gov.ns.ca/just/fatality/htm.

1. INTRODUCTION

Society places a high value on human life, and death investigation legislation provides a mechanism whereby categories of deaths that appear to be "unnatural" may be investigated and explained. The purpose of the *Fatality Inquiries Act* (the *"Act"*) is to examine a sudden death to identify the victim and the cause of death. An understanding of how a death occurred may lead to the prevention of similar deaths in the future, and "public accountability" may be promoted through the scrutiny of the operations of public institutions and agencies when sudden or suspicious deaths occur.

There have been a number of complaints about the *Act* in the past dozen years. Most recently, the adequacy of the statute was questioned in the context of the events associated with the death of a patient in a hospital and the subsequent charging of a physician with first degree murder.

In recent years the *Act* has been amended three times. However, these amendments were minor in nature and there has never been a comprehensive review of the *Act.* As a result, in many ways, the *Act* neither provides a framework for the modern purpose of a death investigation system nor reflects current practices in a number of areas. Currently, it is being reviewed for the purpose of law reform. This paper is provided as background information about the *Act* and as a means of identifying some of the main issues that require legislative and policy decisions.

2. DEATH DEMOGRAPHICS

a) Causes of death

Every year in Nova Scotia, more than 7,600 people die. Death comes to most -- 95 percent or more than 7,200 individuals -- as a result of disease. Of the remaining five percent, about 288 will die as a result of an accident, 113 from motor vehicle related accidents; another 105 or so will take their own lives. Far less than one percent of the total deaths each year -- an average of 17 individuals -- die following an assault. It is striking that suicide claims almost as many victims as motor vehicle related accidents.

The largest concentration of population in the Province is found in the Halifax Regional Municipality. It is, therefore, not surprising that more people --in terms of absolute numbers -- die there than in any other part of the province. However, standardized mortality rates by county for the period 1990-1995 show that death due to accidental and adverse effects is highest in Victoria and Digby counties. The highest rate of death in the Province for all causes of mortality is found in Cape Breton County.

3. NOVA SCOTIA'S CURRENT SYSTEM

a) Appointment of the Chief Medical Examiner for Nova Scotia (the "CME") and medical examiners

Nova Scotia has a medical examiner system of death investigation. The *Act* states that the Governor in Council may appoint both the CME and the chief medical examiners for each county. The CME must be a duly qualified medical practitioner with special training in pathology. The chief medical examiner for a county must be a duly qualified medical practitioner but is not required to hold the additional pathology qualifications. The *Act* also authorizes the chief medical examiner for a county to appoint additional medical examiners for the county, who must also be medical practitioners.

The *Act* is not reflective of the current practice for appointing medical examiners. In practice, no person has been appointed chief medical examiner for a county for the past dozen years. Medical examiners are appointed by the Governor in Council and are supervised by the CME.

It is interesting to note that none of these appointments are mandatory; Cabinet is not required to appoint persons to these positions. Further, while the duties of the chief medical examiner for a county are set out in the *Act*, the duties of the CME are not addressed in the *Act* or Regulations. These issues will be discussed in further detail later in this paper.

b) Death investigation process

The following section provides a brief overview of the current death investigation process. The involvement of a medical examiner begins when they are informed that there is a dead body in their jurisdiction which satisfies one of the following criteria:

a) there is reasonable cause to suspect that the person died by violence, undue means or culpable negligence;

b) the person died in a place or under circumstances requiring an inquest under any statute;

c) the cause of death is undetermined; or

d) the person died in jail or prison.

When any of these circumstances appear to exist, the medical examiner takes charge of the body and inquires as to the cause and manner of death. Once the investigation is complete, the medical examiner prepares a report outlining all circumstances relating to the cause and manner of death. This report is filed with the Prothonotary for the county in which the body was found.

Once the medical examiner's report is filed, the CME or the Attorney General may direct that a post mortem examination be held. If upon examination, personal inquiry or post-mortem examination, the CME is of the opinion that the death was caused by violence, undue means, culpable negligence or that the death occurred in a jail or prison, the CME must send a report to a Provincial Court judge for consideration as to whether an inquest should be held.

The judge is not obligated to hold an inquest when they receive this notice from the medical examiner. The judge calls the inquest only when "he considers it necessary for the full investigation of the cause of death". A Provincial Court judge also has discretion to "institute an inquiry into the circumstances surrounding the alleged death" of a person whose body has not been recovered.

In addition to a judge, the Attorney General or the County Prosecutor may also direct that an inquest be held.

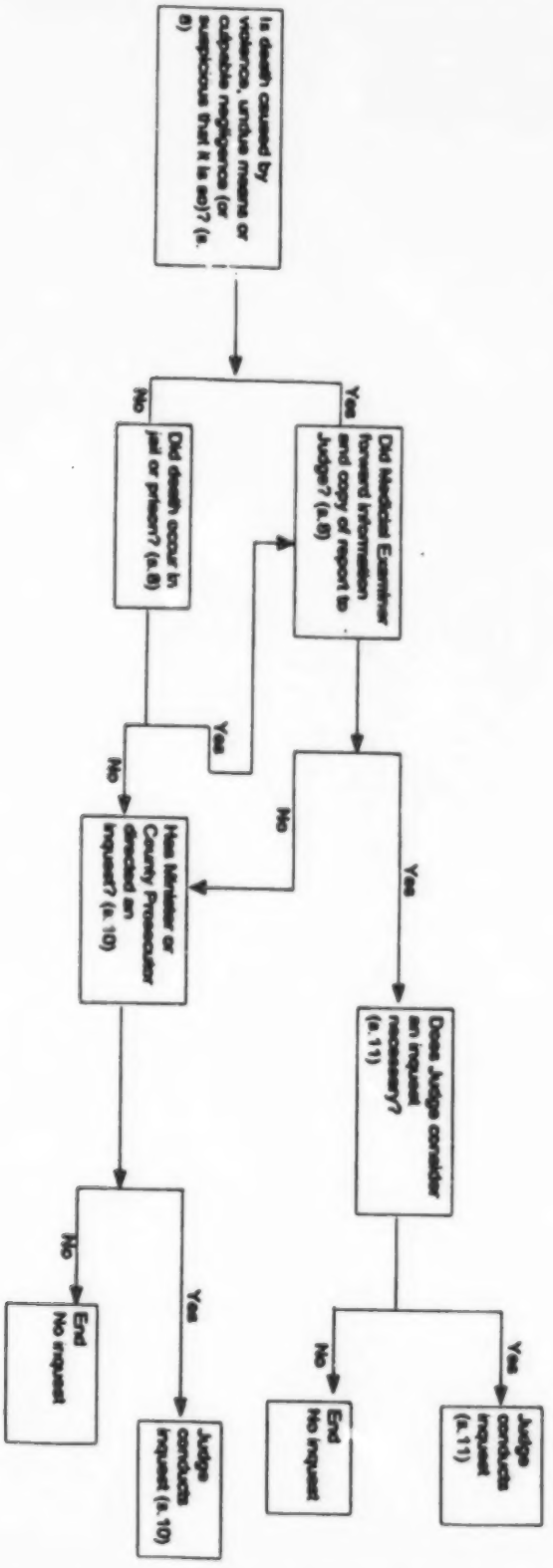
An adjournment or postponement of the inquest is required pending the determination or hearing of a criminal charge, where a judge becomes aware that a "criminal charge has been preferred arising from or related to the death".

Under the *Act*, the judge who conducts an inquest is directed, after hearing the evidence, to make a report "setting forth when, where and by what means the person deceased came to his death, his name, if known, and all material circumstances attending the death". The medical examiner's investigation appears to be confined by law to the physical presentation of the deceased for he or she is instructed to "reduce to writing every circumstance respecting the condition of the body and tending to show the cause and manner of the death". In contrast, the judge is to make findings respecting "all material circumstances attending the death", which would seem to direct the judge to the broader picture. The *Act* also allows the judge to make "recommendations ... with respect to measures that might prevent a future mishap of a similar nature" and may recommend that a further inquiry be held. This is also true in other jurisdictions where coroners or judges are required to make recommendations directed to the avoidance of deaths.

Once the judge's report is filed, the Attorney General may order an additional inquiry if it is "necessary or desirable, in the interests of justice that another inquiry be held".

The inquest process has been the subject of significant criticism and various aspects of this process are examined more fully in this paper.

4. CHART - INQUEST UNDER *FATALITY INQUIRIES ACT*



5. DEATH INVESTIGATION SYSTEMS

a) Medical examiner system vs. coroner system

In the Anglo-American world, there are two systems of death investigation: the coroner system and the medical examiner system. Both the medical examiner and coroner systems are similar in that their involvement is triggered by notification of a relevant death and both a coroner and medical examiner investigate the circumstances of the death.

The main difference between the two systems is that under the coroner system, one of the coroner's primary functions is to conduct a judicial inquiry into a death. The medical examiner's primary role is to reach a conclusion on the cause of death based on an assessment of the deceased's medical history and external or internal examinations of the deceased; the medical examiner does not conduct an inquiry . The ability to ascertain the cause of death from a medical perspective is fundamental to the death investigation system.

In a medical examiner system, physicians, appointed as "medical examiners", have a duty to investigate and establish the medical causes of particular deaths. Unlike coroners, theirs is not a judicial function, but rather a medico-legal or forensic one.

In Canada, there are coroner systems in British Columbia, New Brunswick, the Northwest Territories, Ontario, Prince Edward Island, Quebec, Saskatchewan and the Yukon. Only in Ontario and Quebec are the coroners medically qualified. In Canada, medical examiner systems exist in Alberta, Manitoba, Nova Scotia and Newfoundland.

As noted above, in Ontario coroners are medical practitioners. While coroners do have the jurisdiction to preside over the inquest, the Ontario legislation also enables a legally trained commissioner to be appointed if the inquiry requires this type of expertise.

Under the Ontario statute, there are both mandatory and discretionary inquests. The *Act* requires that inquests be called in respect of deaths that occur in custody, in relation to mining, or on a construction site. The decision of the coroner to hold a discretionary inquest is based upon whether the inquest would "serve the public interest". If a coroner decides not to hold an inquest the person making the request may ask the Chief Coroner to review the decision. The decision of the Chief Coroner is final, subject to the possibility of an inquest being ordered by the Minister.

Nova Scotia has had a medical examiner system since the 1960's when legislation was introduced which eliminated coroners. It is expected that the medical examiner, who is a physician, will bring "medical expertise to the evaluation of the medical history and physical examination of the deceased".

While there are coroner systems which are highly effective death investigation systems, for example the Ontario system, most coroner systems reflect their former function as adjuncts of the criminal justice system, a role no longer accepted within Canadian law.

Just as coroner systems cannot have a criminal purpose under Canadian constitutional law, neither can the object of a medical examiner system be a determination of criminal responsibility. In Canada, the detection of crime is an important result of the work of a coroner or a medical examiner. It is a product of the system, however, rather than its primary purpose.

There are those who believe that the sensible choice for Nova Scotia is to reform the existing medical examiner system and the issues raised in this paper are, for the most part, based on this premise. However, given the number of problematic issues which have arisen with the present system, a full examination of this subject matter mandates an examination of whether Nova Scotia would be better served with a coroner system as opposed to a reformed medical examiner system.

Should Nova Scotia continue with a medical examiner system of death investigation or should the coroner system be considered?

b) Statutory process for establishing the medical examiner system

One of the first issues to consider is whether the revised legislation should mandate the establishment of a death investigation system. At present, under the *Act*, the appointment of any medical examiner, including the CME, is at the discretion of the Governor in Council. Nova Scotia is not alone in leaving it to the Executive to decide whether coroners or medical examiners will be appointed.

However, in Nova Scotia, the Governor in Council is obligated to appoint an Auditor General, a Chief Electoral Officer, a chair of the Gaming Control Commission plus a long list of others under more than 20 provincial enactments. Why should the appointment of the CME and medical examiners be any different?

Should appointments of the CME and medical examiners be mandatory under the *Act*?

Not having a mandatory system requiring the appointments of the CME and medical examiners raises the following questions:

- **Is it an option for government to conduct itself without the services of medical examiners investigating "sudden" deaths?**

- **What would be the implications if the Executive were to conclude that medical examiner offices did not need to be filled?**

6. ROLE OF THE CME

a) Qualifications, responsibilities and powers of the CME

The Province is served by a Chief Medical Examiner for Nova Scotia who is appointed by the Governor in Council and holds office during pleasure. The appointment is at the discretion of government and the office has been in existence only since 1984. There is no provision for a person to act in the absence of the CME.

The CME must be: (1) "a duly qualified medical practitioner who has special training in pathology", (2) "registrable in the Medical Register of the Province of Nova Scotia as a pathologist", and (3) meet "any other additional requirements prescribed by the regulations". The requirement that the CME be a pathologist became effective on May 1, 1995. At the same time, a new and highly particularized Section 31 was added to the *Act* authorizing the Governor in Council to make regulations in respect of requirements for the CME. To date, no regulations have been made under this Section.

The CME has supervisory powers over all other medical examiners in the Province. Under subsection 2(7), the CME also has those duties and powers which are conferred or imposed on him/her by the Governor in Council or the Attorney-General. The former appears to have issued no orders in council assigning duties to the CME. However, the Attorney General had assigned responsibilities to a former CME under his contract of employment which included:

a) providing consultation and advice to medical practitioners, pathologists, police, Crown Attorneys and lawyers;

b) directing investigations and handling complex cases which require expertise in forensic pathology;

c) performing autopsies;

d) presenting expert evidence as required at inquests or in court; and

e) performing all related administrative responsibilities affiliated with the Office of the Medical Examiner.

The *Act* provides only the barest sketch of the actual responsibilities of a chief medical examiner and is ambiguous as to whether the CME actually takes on the duties of medical examiners, although in practice the CME does assume these duties. In several Canadian jurisdictions, the duties or responsibilities of the chief medical examiner have been set out in statute in considerable detail.

How should the qualifications, responsibilities and powers of the CME be expressed in the legislation?

b) The independence of the CME

The Ontario Law Reform Commission, in its 1995 review of the death investigation legislation in that province, recommended that "all coroners should be, and should be perceived to be, independent of local institutions". The Saskatchewan Law Reform Commission proposed that one of the purposes of revised coroners' legislation would be to "provide for independent, impartial investigation into circumstances surrounding deaths".

The position of the CME, like the Director of Public Prosecution or the Auditor General, is strictly statutory and therefore subject to legislative scrutiny. The CME must be independent of political interference in the conduct of their work, but because all legal authority must be traced to the legislative body, the CME must be accountable to either a member of the executive (e.g. the Attorney General) or to the House itself. Each office holder is accountable to a member of the executive, or the legislature, but some clearly function at a greater distance from the immediate involvement of the legislature or the executive on the day to day running of the affairs of the office.

An important distinction may be added here: the CME acts under statutory authority, not under the authority of the Attorney General. The CME is accountable to the Attorney General for the performance of their duties, but not for their opinions on the cause and manner of death.

In a number of American jurisdictions, medical examiners are not attached to the Attorney General's department. In lieu of a chief medical examiner who reports to a member of the executive, some jurisdictions have established independent agencies with boards of directors overseeing the activities of medical examiners.

Within Canada, there are examples of boards or commissions overseeing the activities of medical examiners and coroners. In Ontario, a Coroners' Council is established under the legislation to monitor the conduct and performance of coroners and to recommend disciplinary action to the Minister where necessary. The Fatality Review Board in Alberta has similar duties in addition to being responsible for making recommendations to the Minister respecting inquests.

How independent should the CME be and how should the office be structured to ensure the appropriate level of independence?

Other questions which have an impact on the independence issue include:

- **How should the CME's employment relationship be formulated; should it be an Order-In- Council appointment as it is under the current *Act* or would the independence of the office be more appropriately addressed if the CME were hired under the *Civil Service Act*?**
- **What should the term of office be for the CME?**
- **What are the grounds for removal of the CME and should they be specified in legislation?**
- **What are the appropriate accountability mechanisms over the CME?**
- **If the CME continues to have a reporting relationship with government, is the Department of Justice the most appropriate Department to fulfill this role?**

7. ROLE OF MEDICAL EXAMINERS

a) Responsibilities and powers of medical examiners

In Nova Scotia, every medical examiner in the Province is required to be a "duly qualified medical practitioner". Outside the larger centres, medical examiners are typically family physicians with authority under the *Act* to engage a specialist to conduct an autopsy when it is needed. For many physicians the attractions of medical examiner service are limited -- the fees for service are low and the hours irregular. Many medical examiners estimate that they spend two to three hours responding to a typical sudden death call, and many find it awkward to leave their practices when notified of a death. The fee per case is $80. In 1988, the Joint Committee of the Nova Scotia Medical Society and the Nova Scotia Barristers' Society concluded that medical examiners are not well paid for their services, and recommended that the fees paid to medical examiners be reviewed and revised.

The *Act* sets out the powers and responsibilities of the county chief medical examiners -- for which will be read here "medical examiners" -- to be those in respect of the medical cause of death: taking charge of the body; investigating the death; entering premises where a dead body is believed to be and removing it; taking charge of any money or other personal property of the deceased found on or near him; delivering the personal effects to the RCMP or police; performing autopsies or engaging another medical practitioner to do the autopsy; authorizing the extraction of the pituitary gland; engaging the services of experts where needed; releasing the body; preparing a report setting out the results of the investigation respecting the cause and manner of death; and filing this report with the Clerk of the Crown. Where suspected child abuse is involved, this must be reported to the Child Abuse Register.

Over a decade ago, in 1988, a Joint Committee of the Nova Scotia Medical Society and the Nova Scotia Barristers' Society expressed the opinion that the duties and powers of medical examiners as set out in the *Act* were insufficient as a guide to medical examiners. The Committee stated that "there is virtually no direction in the *Fatality Inquiries Act* regarding the procedures which medical examiners should follow in conducting investigations". In other jurisdictions, the Committee continued, medical examiner manuals had been developed which "contain comprehensive guidelines regarding the nature and scope of the duties of medical examiners .... they [the guidelines] can also serve to put in place uniform procedures throughout the Province".

This issue of the lack of training of medical examiners in Nova Scotia was the focus of an inquest where the judge found that the circumstances of a particular death should have resulted in the medical examiner performing a prompt autopsy followed by a fatality inquiry. However, the judge accepted the evidence of the medical examiner that his appointment as a medical examiner was a very casual affair and that he received little or no training.

The insufficiency of direction of medical examiners was also commented on by the Registrar of the Provincial Medical Board who wrote the Deputy Minister of Justice in 1992 respecting a discipline hearing where a medical examiner was interviewed. The medical examiner (who was not the subject of the discipline hearing) stated in the interview that he had never received instructions respecting his duties or obligations and had never seen a copy of the *Fatality Inquiries Act*.

Looking at the *Act* itself, it is clear that the responsibilities of medical examiners are many in Nova Scotia and comparable to those of similar office holders in other jurisdictions. For the most part, a comparison of legislation shows that enactments provide for (1) the jurisdiction of the medical examiner or coroner; (2) the responsibilities and powers of the medical examiner in investigating a death; (3) duties respecting the release of the body when the investigation is completed; (4) the preparation of certain reports; and (5) the medical examiner or coroner's role in the calling of inquests.

A number of Canadian jurisdictions have incorporated the following five-pronged requirement in legislation outlining the purpose of a medical examiner's investigation into a death:

1. the identity of the deceased;
2. the time of death;
3. the place of death;
4. the medical cause of death; and
5. the manner of death.

Should the *Act* set out the responsibilities and powers of medical examiners?

If the essential requirement of the medico-legal investigation is agreed to be the correct identification of the five particulars in respect of each death investigation, this should be set out in the legislation. The inclusion of additional objectives ought to reflect the responsibilities assigned to the CME and other medical examiners under the revised legislation, a consideration of the extent of the public's right to know about the deaths of individuals in general, and the resources available to perform the functions assigned as objectives.

b) Role of non-physicians in death investigation process

Under optimum conditions, medical examiners or coroners who are physicians go to the scene of a death, see the body, and conduct an investigation. They also deal with family members if they are present at the scene of death. In some jurisdictions, because of the cost associated with having physicians undertake all the duties of medical examiners, persons who are not physicians are appointed as medical investigators. These individuals, working under the supervision of a medical examiner who is a physician, usually have a health science background (e.g. nurses, pharmacists).

In Alberta and Newfoundland, the legislation allows for the appointment of investigators to work with medical examiners. In Nova Scotia, a pilot project is underway in Kings County where nurse investigators are assisting medical examiners. The assessments of the project have been very positive and the term of this pilot project has been extended. Within Halifax-Dartmouth -- and not county-wide -- nurse investigators have been assisting the CME's office for the past three years and play a key role in the system.

Should the *Act* specifically provide for the role of non-physicians and, if so, what should their role be?

c) The relationship between the medical examiners and the police

The *Act* directs every police officer to notify the medical examiner of deaths requiring examination by him or her and also to give the medical examiner "all police assistance that he requires in the discharge of his duties and generally aid and assist the medical examiner in the performance of his duties under this Act".

In addition, the RCMP has a specific responsibility to deliver that property of the deceased gathered by the medical examiner "on or near the body" to the "person or persons entitled to its custody or possession". .

From an operations perspective, the police and the medical examiner have to work closely together. Generally, the medical examiner will be the third party to the scene of a death, and only after being informed by the police that they are needed. While only the medical examiner is directed by statute to investigate a suspicious death, it is accepted that the police have the responsibility for directing a criminal investigation. This relationship is integral to the credibility of the death investigation system and in the past there have been concerns raised by both parties as to their respective roles and responsibilities in this process.

Alberta has gone so far as to set out in statute the roles of these parties. The interrelationship between the police and medical examiners is explained in Alberta as follows: when a criminal matter is suspected, the police take charge of the investigation, and the medical examiner assists the police. However, when it is clearly a medical examiner case, the medical examiner takes charge and the police assist the medical examiner. In either instance, the medical examiner is always neutral in their approach to the case.

Should the roles of the police and medical examiner be set out in the *Act*?

A satisfactory system would be one where medical examiners and police work cooperatively and where their respective areas of expertise are recognized. Incorporating this relationship into legislation may alleviate some concerns and assist all parties in understanding their respective roles within this system.

8. REPORTABLE DEATHS

a) Obligation to report deaths

Under the *Act* police officers have a duty to notify the medical examiner of a sudden or unexpected death, and corrections officials are bound to report deaths in prisons or jails. No others have this duty under the *Act* and the medical examiner's authority is triggered only when they are informed of a body within their territory that may be categorized under subsection 5(1).

The fact that the duty to report is so limited was brought to the public's attention in recent years in the events surrounding the death of a hospital patient in Nova Scotia and the subsequent charging of a physician with murder. During that time a newspaper article reported that "none of the proper authorities was notified of the patient's death, including the province's chief medical examiner...".

The external review team, commissioned by the hospital that investigated the patient's death, stated that they considered the *Fatality Inquiries Act* "deficient in failing to mandate a report of such deaths [where an individual dies by violence, undue means or culpable negligence] to the Medical Examiner, even though this could be deemed to be a responsibility of any reasonable citizen." They recommended that the *Act* be amended "to include a duty on the part of any citizen" to notify the CME of a Section 5 death.

b) Categories of deaths

The *Act*, under s. 5(1), requires that a chief medical examiner investigate four categories of deaths when informed of a body lying within his or her territory:

1. where "there is reasonable cause to suspect that the person died by violence, undue means or culpable negligence";

2. where the person died in a place or under circumstances requiring an inquest under any statute;

3. the cause of death is undetermined; or

4. the person died in jail or prison.

Today, the importance society places on understanding the reasons underlying "misadventures" or accidental deaths is clearly different from what it was centuries ago. In practice, in Nova Scotia, the sorts of deaths reported to medical examiners are those which can be described as "sudden" or "unexpected".

From looking at legislation in other jurisdictions as well as Nova Scotia, it would appear that the reportable deaths fall into at least one of the following broad categories:

1. sudden, violent, or unexpected deaths;

2. deaths related to medical procedures, or lack of medical procedures or care;

3. deaths in institutions where residents are either "vulnerable" because of their age, state of health, or mental capacity, or where they are held against their will; and

4. workplace related deaths; and

5. deaths of children under particular circumstances.

Deaths in health care facilities

In Nova Scotia, more than 60 percent of all deaths (in excess of 4,000 annually) take place in hospitals. How do we determine which of these deaths ought to be investigated and which not?

Deaths in correctional institutions

Nova Scotia requires that deaths in jails or prisons be reported to medical examiners by the superintendent of the institutions.

Deaths of children

Reports of deaths of children from abuse or neglect and the failure of social agencies to identify those at risk have been the focus of concern in recent years. In Nova Scotia, the *Fatality Inquiries Act* requires the reporting of a death due to suspected child abuse.

Workplace deaths

Under the *Occupational Health and Safety Act*, an employer must report a workplace death within 24 hours to the Executive Director of Occupational Health and Safety. No one is to disturb the "scene of the accident" unless it is necessary to prevent further injuries, to protect property or "to attend to persons injured or killed". While the *Act* is silent on the issue, Department of Labour policy results in an investigation into the event in order to determine whether there has been a violation of the *Occupational Health and Safety Act* that led to the death. Similarly, where a fatality was associated with an elevator, the inspector, under the *Elevators and Lifts Act*, would conduct an investigation into the cause of the accident but his focus would be on the workings of the elevator to determine if there were violations of that *Act* which led to death. Both of these investigations are distinguishable from the medical examiner's whose focus is determining the medical cause of death of the individual.

Does the *Act* accurately reflect the types of deaths which should be investigated? If not, how should the *Act* be amended to ensure that it covers the appropriate categories of deaths?

9. INFORMATION GATHERED UNDER THE *FATALITY INQUIRIES ACT*

a) Medical examiners' files

In the course of an investigation into a death, the medical examiner will gather documentation about the deceased. A case file could include summaries of the deceased's medical history including copies of medical tests, psychiatric history reports, investigators' reports, toxicology reports, an autopsy report, witness statements, photographs of the deceased, ambulance reports and police reports. A completed file would also contain a copy of the report prepared by the medical examiner once their investigation is completed and a copy of the medical certificate of death.

In both Alberta and Newfoundland, the legislation specifically provides that all the information gathered is the "property of the government of the province and shall not be released without the permission of the Chief Medical Examiner".

In Nova Scotia, the practice of medical examiners is to release a copy of the medical examiner's report and the autopsy report (where conducted) to the family or the representative of the deceased when it is requested. Where the family consents, these same documents may be released to others.

Information in the file is subject to the *Freedom of Information Act*. Much of it is third party documentation such as hospital records or police reports. It is the view of the Department of Justice that the information respecting the deceased attracts the privacy protections of the *Freedom of Information Act*.

The release of the medical examiner's file is not addressed in the *Act*. Should it be?

b) Reports

i) Inquest Reports

At the conclusion of an inquest in Nova Scotia, the *Act* directs the judge to "make a written report setting forth when, where and by what means the person deceased came to his death, his name, if known and all material circumstances attending the death". This report together with the notes or transcript, if any, of the evidence and any exhibits tendered at the inquest is then to be filed with the clerk of the Court. The inquest is a public event, although it may be held in private under the *Act*.

ii) Medical Examiners' Reports

While it is clear that the reports of an inquest are public documents -- as an inquiry is a public event -- it may be that reports of medical examiners can be considered as something less public as they may contain personal information that should attract privacy protection. Under current practice, the reports of medical examiners are accessible to the public once they are filed at the court office. Is there reason to continue this procedure? In the early part of the 19th century there may have been sound policy reasons for this practice. First, it made sure that all "inquisitions" were reported in a central place, and that the findings of inquests were publically accessible. Second, it ensured that a coroner would only be paid for inquests he had actually conducted.

Most reports do not attract attention. However, where a prominent individual has taken their own life, it is not uncommon for the particulars of the manner of death to appear in the press causing additional pain to family members. Consideration may need to be given to balancing the public's interest in an individual's death -- to ensure there has been no foul play and to ascertain whether it could have been prevented -- with the sensitivity the community customarily accords the family of an individual on his death.

In Alberta, under s. 30 of the statute, medical examiners' reports are kept at the office of the Chief Medical Examiner. Each medical examiner provides the Chief Medical Examiner with a "record of the investigation and the reports, certificates and other documents ..." in respect of each deceased.

In Nova Scotia, in addition to the filing of the medical examiner's report with the Prothonotary, information from the investigation is reported to the Vital Statistics office through the completion of the medical certificate of death. A protocol between Vital Statistics and Statistics Canada leads to the incorporation of this data in a national, as well as, a provincial database. The particulars on the certificate are coded by Statistics Canada with factors identifying the individual stripped from the record. The data is then available to federal and provincial departments of health and other researchers for analysis. Some of this information is published by the office of Vital Statistics in its annual reports.

Who should be entitled to receive the information gathered under the *Act* and should this be addressed in legislation?

Related to the issue of who should be entitled to receive a copy of the medical examiner's report is the question of what the report should contain. Many jurisdictions, including Nova Scotia, direct the coroner or judge conducting an inquest to make recommendations in their reports which may, as subsection 16(3) of the Nova Scotia reads, "prevent a future mishap of a similar nature".

Whether the purpose of the legislation is to go beyond providing for a method for responding to certain categories of deaths by including a proactive method of responding to the deaths at the medical examiner stage by alerting the public, business and government to potentially dangerous practices or structures which may have contributed to deaths is a very interesting question.

Should the *Act* confine the medical examiner to speak only to the cause of death or should the medical examiner have more expansive powers to address a broader range of issues in their report?

If the latter view is taken, do medical examiners have sufficient qualifications to comment on these broader issues?

10. INQUESTS

a) Purpose of an inquest

Inquests in Nova Scotia are conducted by Provincial Court judges. The purpose of an inquest is to investigate an unnatural death by calling witnesses and presenting evidence. It is a public, judicial proceeding, though there are no parties, and is similar in many respects to an inquiry under the *Public Inquiries Act.*

In Nova Scotia, the inquest is only concerned with a particular subset of unnatural deaths, that is those where a chief medical examiner is (1) of the "opinion that the death was caused by violence, undue means or culpable negligence or that there is reasonable grounds for suspecting that the death may have been so caused"; and (2) those "where death occurs in a jail or prison".

Justice David Marshall, in his review of death investigation systems in Canada, sees the function of the modern inquest to be threefold:

1. to ascertain publicly facts relating to suspicious deaths;

2. to focus community attention on those circumstances; and to initiate community response to preventable death; and

3. to serve as a means for satisfying the community that the circumstances surrounding the death of one of its members will not be overlooked, concealed, or ignored.

In addition to the role the inquest may play in answering questions about a death and educating the public about "preventable deaths", the Ontario Law Reform Commission Report also saw the inquest as serving as a method of inquiring into "deaths that may have resulted from misconduct, neglect or culpable conduct, in order that similar deaths may be avoided in the future". Further, the Law Reform Commission viewed the inquiry as a means of examining the effectiveness, fairness and lack of discrimination of regulatory, law enforcement, custodial, or health and safety agencies. The recommendation function of the inquest was also noted.

In Canada, only Newfoundland does not set out in its death investigation legislation what an inquiry into a death is to determine. In the rest of the country, the issues to be determined comprise for the most part the elements of the traditional coroner's inquisition or verdict.

While an inquest might investigate a death "that may have resulted from misconduct, neglect or culpable conduct" -- to use the words of the authors of the Ontario Law Reform Commission Report -- it may not reach a conclusion which assigns blame for the death to an individual. In some jurisdictions the legislation specifically prohibits a finding of legal responsibility.

The Nova Scotia *Fatality Inquiries Act* is silent respecting findings of legal responsibility. However, until 1992, when clause 16(1)(b) was repealed, a judge was directed to name the individual or individuals responsible where he had concluded that "the death resulted, in whole or in part, from the unlawful act or culpable negligence" of these persons.

It appears clear today that whether or not the death investigation legislation refers to findings of criminal or civil responsibility, decisions of the Supreme Court of Canada lead to the conclusion that it is best for decision makers to avoid such findings.

Nonetheless, even with prohibitions against findings of responsibility -- criminal or civil -- from various sources, it is frequently difficult for witnesses to be properly protected against adverse conclusions respecting their conduct. David Marshall writes, "the problem of the suspect who has never been charged remains, as does the problem, for individuals, of devastating media coverage of the inquest."

b) Mandatory inquests

The number of inquests held in any one year in Nova Scotia is remarkably few: indeed, since 1988, there have been a total of 20 inquests in this province. A decade ago, there were complaints from some members of the judiciary that there were too many unnecessary inquests; public prosecutors were also concerned with the time required.

There have been no mandatory inquests in Nova Scotia for more than 50 years. In many Canadian jurisdictions, an inquest will be called where a person dies in custody in any form of a correctional institution, or where a person dies while detained or in the custody of the police. Ontario also requires an inquest, under subsection 5(2) of the Ontario Act where a worker dies "as a result of an accident occurring in the course of the worker's employment at or in a construction project, mining plant or mine, including a pit or quarry". In Manitoba, mandatory inquests are required where a person dies while a resident of a psychiatric facility or a "development centre" defined in the Manitoba *Vulnerable Persons Living with a Mental Disability Act* and where there is reason to believe that death was a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause".

Another approach found in Canadian jurisdictions is to direct an inquest where certain conditions exist. Alternatively, where the conditions exist medical examiners are obliged to notify a higher authority that consideration should be given to an inquest. These conditions may include institutional or workplace deaths. Others may allow for interpretation on the part of the official making the recommendation, such as where there is incomplete information about a death, where the public purpose will be served, or where safety or accident prevention is an issue.

Should the *Act* provide for mandatory inquests and, if yes, under what circumstances should a mandatory inquest be called?

c) Utility of the inquest

Arguments may be advanced that inquests have outlived their usefulness. For example, issues of criminal responsibility no longer have any place at an inquest, and it is inappropriate for an inquest to review cases involving death by "violent, undue means, or culpable negligence".

An inquest has the potential to interfere with police investigations, or to confound the process altogether, and may not be the best forum for examining the underlying social, occupational, or health factors related to deaths. Also, a discrete inquest function is unnecessary because government has other means of directing inquiries should it choose, such as an "independent review" of a death, or an inquiry under the *Public*

Inquiries Act. There are also other methods for government to obtain recommendations respecting measures which might have prevented the death.

Though inquests are rarely used in Nova Scotia, it is not clear why this is so. A public inquiry under the *Public Inquiries Act* may carry out many of the same functions. However, a principal distinguishing factor between an inquest under the *Fatality Inquiries Act* and one under the *Public Inquiries Act* is that the calling of the inquest, at least under the current *Act*, does not require the intervention of the Attorney General. Neither do terms of reference have to be drafted because the *Act* sets the parameters.

This discussion raises the following questions:

- **Is the fact that inquests are so seldom called in Nova Scotia an indicator that the function is outmoded and no longer of use?**
- **Has the inquest function been completely replaced by investigations by medical examiners and the police?**
- **Should the revised legislation be restricted to the medico-legal stage only?**

d) Power to call an inquest

In Nova Scotia inquests may be called by a Judge, a prosecutor or the Attorney General. The CME does not have the jurisdiction to call an inquest.

The present method of allowing a judge, the prosecutor for the county, and the Attorney General the opportunity to call an inquest may have been designed as a method of reducing the danger of coverups by spreading this authority among three parties who could be seen to reflect legal, local, and general public concerns. At the same time, the authority of the Attorney General to order an inquest under Section 10 allows for a situation where the Attorney General may be seen to be overruling a decision of a Provincial Court Judge. Theoretically, a judge could conclude under Section 11 that there was no need for an inquest but could be directed to conduct one nonetheless under Section 10.

The following questions should be considered:

- **Is it appropriate to permit a situation where either the Attorney General or a prosecutor "overrule" a judge in a decision to call/not call an inquest?**
- **Should the Attorney General continue to have authority to order an inquest?**
- **Should the CME have the authority to order an inquest?**
- **Is there merit in perpetuating a right for Crown attorneys to call inquests?**

e) Role of prosecutors in the conduct of inquests

In addition to the authority the prosecutor of a county has to call an inquest, the prosecutor also has the authority to attend the inquest on behalf of the Attorney General and cross-examine the witnesses.

Given the fact that the prosecutor is no longer needed to assist on points of law as the inquest is conducted by a judge, would the system be better served if the Attorney General appointed counsel for the Attorney General?

Does the involvement of the prosecutor make the process too "criminal" when that is clearly not the aim of the inquest?

CONCLUSION

As noted earlier, there have been concerns raised about Nova Scotia's current death investigation system. This paper has attempted to highlight the major issues for consideration in a way which will encourage input and comment from the numerous interested parties.

The goal of this process is for legislation to be drafted following consultation with interested parties that will ensure the process serves the needs of all of those involved in the death investigation system.

In order to ensure this occurs, please forward any written submissions by March 31, 2000. There is no requirement that all of the questions posed in the paper be addressed in your submissions as all of the questions are not relevant to all interested parties.

Please respond to as many or few questions as you would like. Responses should be directed to:

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